MH 515 NCR
Revised 03/31/11

PROGRESS NOTE

☐ Continued **(Sign & complete claim information on last page of note.)** **Service is Medi-Cal Claimable (Check one):** ☐ **Y** ☐ **N**

By signing my name below, I attest that I have provided the mental health services recorded on this NCR note form and that all information is accurate, complete & truthful to the best of my knowledge. I further attest that the services provided by me, as reflected on this NCR Note form, were consistent with the client's treatment plan, and, if services are to be claimed to Medicare and/or Medi-Cal, were reasonable and medically necessary. Claim for services submitted as a result of this NCR Note form are supported by documentation.

Signature & Discipline _____ Date _____ Co-signature & Discipline (if required) _____ Date _____

Service Date: **Telephone Contact:** ☐ Y ☐ N **Procedure Code:** **Group ID #:** **# Group Participants:**

MHS Activity Type: ☐ Ind Tx ☐ Ind Reh ☐ CoI ☐ PsyT ☐ GrpTx ☐ GrpReh ☐ Team Conf/CaseCon **Other Activity Type:** ☐ Cris Int ☐ TCM

Place of Service: **1. Address:**

Evidenced Based Practice (EBP) Service Strategy (SS) (See IS Codes Manual for a listing of Codes):

Rendering Provider Name: **Staff Code:** **Face-to-Face/OtherTime* (Hrs:Mins):**

Staff Name: **Total Activity Time* (Hrs:Mins):** **Staff Name:** **Total Activity Time* (Hrs:Mins):**

Client Present: ☐ Y ☐ N **# Collaterals:** **Relationship(s):** * All travel and documentation time must be recorded as "**Other" or" Total Time.**"

2. EPSDT Screening Referral: ☐ Y ☐ N **3. Pregnancy:** ☐ Y ☐ N **4. Emergency:** ☐ Y ☐ N **5. SED:** ☐ Y ☐ N **6. Share of Cost:** ☐ Y ☐ N

Plan:

Review Initials: **(FOR CLERICAL STAFF ONLY)** **Data Entry Initials:**

Medi-Cal Late Code: **A B C** **Medicare Beneficiary:** **Y N** **Crossover Code:** **X B P H N E P**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: **IS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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